State of Arizona Advertising Transmittal and Certification Form

NAIC # _____
Company Name _____
Company Address _____
_____
_____

For Department of Insurance Use Only

Date Received _____
Analyst _____
Filed: Date_____ Initials_____

Type of Entity: Insurance Company
Health Care Services Organization
Hospital, Medical, Dental, Optometric Service Corporation
Prepaid Dental Plan

Contact Person* _____ Title _____
Telephone Number _____ FAX Number _____

Type of Advertising Material Being Filed:

Radio Commercial	Television Commercial	Brochure
Billboard	Magazine	Newspaper
Internet Web Site	Mailer	Response Card
Other_____ (Describe)		

Planned Use:

Date advertising form(s) will first be used _____
Markets advertising form(s) will be used in _____
Number of times advertising form(s) will be shown or printed _____

Product(s) Being Advertised:

Cancer/Specified Disease	Major Medical	Vision Care
Dental	Medicare Risk	Prepaid Dental
Hospital Surgical	Medicare Select	HCSO
Hospital Indemnity	Medicare Supplement	Other_____ (Describe)
LTC/Home Healthcare		

Form Number	Form Name

Note: Additional forms should be listed on a separate sheet and attached to this Transmittal Form.

Company Officer Certification

I have reviewed or supervised the review of the above forms. To the best of my knowledge and belief they are in conformance with applicable provisions of Title 20, Chapter 6 of the Arizona Revised Statutes, Chapter 20 of the Arizona Administrative Code and applicable orders by the Director of Insurance. I also acknowledge responsibility for the validity, accuracy and completeness of transmittal and enclosures in this filing.

_____
Signature of Company Officer/Health Plan Corporate Officer

_____ _____
Typed Name and Title Date

*Person you have designated to receive any 5-day notice.